

**United States Department of Labor
Employees' Compensation Appeals Board**

_____)	
W.C., Appellant)	
)	
and)	Docket No. 09-1362
)	Issued: April 9, 2010
U.S. POSTAL SERVICE, MID-AMERICA)	
PERFORMANCE CLUSTER, Kansas City, MO,)	
Employer)	
_____)	

Appearances: *Case Submitted on the Record*
Appellant, pro se
Office of Solicitor, for the Director

DECISION AND ORDER

Before:
DAVID S. GERSON, Judge
COLLEEN DUFFY KIKO, Judge
JAMES A. HAYNES, Alternate Judge

JURISDICTION

On May 4, 2009 appellant filed a timely appeal from an April 17, 2009 merit decision of the Office of Workers' Compensation Programs concerning his schedule award. Pursuant to 20 C.F.R. §§ 501.2(c) and 501.3, the Board has jurisdiction over the merits of this claim.

ISSUE

The issue is whether appellant has established that he has greater than 12 percent impairment of his right hand, for which he received a schedule award.

FACTUAL HISTORY

On January 10, 2007 appellant, then a 58-year-old maintenance mechanic, injured his right hand when it was caught between a belt and rollers on machinery. He stopped work on January 10, 2007 and sought emergency room treatment. The Office accepted the claim for crushing injury of right hand, except fingers, and right hand abrasion or friction burn without infection. Appropriate compensation benefits were authorized.

A January 10, 2007 right hand x-ray revealed moderate to marked soft tissue swelling about the wrist and hand. A small cortical lucency was seen involving the ulnar styloid and the possibility of a nondisplaced ulnar styloid fracture could not be excluded.

In a February 19, 2007 report, Dr. Keith R. Hodge, a Board-certified plastic surgeon, noted the history of the January 10, 2007 injury and advised that there were no fractures and no surgery. Appellant had current complaints of numbness to the dorsum of the hand as well as the middle, ring and small fingers extending around to the palmar surface. The thumb and index finger had normal sensation. Examination findings included a remnant of a wound on the dorsum of the right hand and limited motion of the middle, ring and small fingers. The hand remained stiff and edematous. Dr. Hodge diagnosed a crush to the right hand. He recommended physical therapy and continued noting appellant's status.

In a July 20, 2007 report, Dr. Dennison R. Hamilton, a Board-certified occupational medicine specialist and second opinion physician, reviewed the medical evidence, statement of accepted facts and provided findings on physical examination. He concluded that appellant had right hand third and fourth digit chronic metacarpal phalangeal sprain with loss of range of motion directly related to his crush injury. Dr. Hamilton stated that there were no motor, sensory or reflex deficits involving the right upper extremity except weakness in right hand with regard to simple and power gripping. He opined that appellant could not return to his date-of-injury position, but could work with restrictions on repetitive use or power gripping of right hand.

On August 23, 2007 appellant claimed a schedule award. On August 30, 2007 the Office advised appellant of the type of medical evidence needed to support his claim. This included medical evidence providing a detailed description of the permanent impairment causally related to the accepted work injury in accordance with the fifth edition of the American Medical Association, *Guides to the Evaluation of Permanent Impairment* (A.M.A., *Guides*).

In an October 24, 2007 report, Dr. George Varghese, a Board-certified physiatrist and an Office referral physician, noted the history of injury and appellant's treatment, reviewed the statement of accepted facts and provided findings on physical examination. At the third and fourth digit of the proximal phalanges, he found impaired sensation to light touch in the distal aspect of the right hand at the volar and dorsal surfaces. Dr. Varghese found limited range of motion in the third and fourth digit with flexion and extension of the metacarpal phalangeal (MP) and proximal interphalangeal (PIP) joints. Muscle strength distally was 4+/5 with finger flexion, abduction, adduction, wrist flexion and extension. Appellant's grip was within normal limits. Dr. Varghese opined that appellant reached maximum medical improvement and used the fifth edition of the A.M.A., *Guides* in determining impairment. He advised that range of motion was determined by using a goniometer. For the third digit at the metacarpal joint, Dr. Varghese provided a total 20 percent impairment. He found under Figure 16.25, an extension of 10 degrees resulted in 3 percent impairment and flexion of 60 degrees equaled 17 percent impairment. At the PIP, Dr. Varghese found 24 percent impairment. He found 10 degrees extension resulted in 0 percent impairment and 60 degrees extension resulted in 24 percent impairment. Under Figure 16.21, Dr. Varghese provided a zero percent rating for the distal interphalangeal (DIP) joint. He used the Combined Values Chart to find a 39 percent rating for the third digit. Under Table 16.1, Dr. Varghese converted the digit rating to seven percent hand impairment and, under Table 16.2, converted the hand rating to six percent right upper extremity impairment. For the fourth digit metacarpal joint, he provided 20 percent impairment. Dr. Varghese found an extension of 10 degrees resulted in 3 percent impairment and flexion of

60 degrees equaled 17 percent impairment. At the PIP, he found 30 percent impairment comprising of 0 percent impairment for 10 degrees extension and 30 percent impairment for 50 degrees flexion. Dr. Varghese found 44 percent impairment for the fourth digit under the Combined Values Chart, which he converted to 4 percent hand impairment under Table 16.1 and 4 percent right upper extremity impairment under Table 16.2. He indicated that, since he was not supposed to take preexisting conditions into consideration, the sensory deficit along with the posterior antibrachial cutaneous nerve was used, which resulted in one percent rating. Dr. Varghese found 20 percent sensory deficit or Grade 4 under Table 16.10 which, when multiplied by the 5 percent maximum sensory deficit impairment under Table 16.15, resulted in 1 percent rating. He found no impairment for pain as it was secondary to range of motion limitation, which had already been rated. Dr. Varghese further stated no impairment rating was offered for muscle strength. He concluded that appellant had a total impairment rating of 11 percent for his right upper extremity.

In a November 3, 2007 report, an Office medical adviser reviewed the evidence of record. On the basis of Dr. Varghese's report, he opined that appellant reached maximum medical improvement on October 22, 2007 and had 12 percent permanent impairment of the right hand. The medical adviser stated that, since two digits of the hand were involved, the digit ratings had to be converted to hand ratings under Table 16-2, which Dr. Varghese did. He advised the hand rating due to range of motion limitation was 11 percent, which consisted of 7 percent impairment of the third digit and 4 percent impairment of the fourth digit. The medical adviser noted that, while Dr. Varghese offered one percent upper extremity impairment rating due to a sensory deficit, the rating must be maintained as an impairment of the hand. Under Table 16-2, page 439 of the A.M.A., *Guides*, one percent of the upper extremity equaled one percent impairment of the hand. The medical adviser combined the 11 percent range of motion deficit with the 1 percent sensory deficit to obtain a total 12 percent impairment rating of the right hand.

By decision dated November 14, 2007, the Office granted appellant a schedule award for 12 percent impairment of the right hand. The award represented 29.28 weeks of compensation and covered the period October 22, 2007 to May 13, 2008.

Appellant requested an oral hearing before an Office representative which was held telephonically on March 11, 2008. The Office received medical evidence previously of record which included diagnostic tests and medical reports from the University of Kansas Hospital dated January 10, 2007 and medical reports and tests from Dr. Gordon R. Kelley, a Board-certified neurologist, intermittently from January 11 to March 16, 2007. In the March 15, 2007 nerve conduction studies, Dr. Kelley noted abnormalities for the digital potentials from digits in the second, third, fourth and fifth fingers. He advised the findings suggested mild diffuse dysfunction of the sensory branches of the median and ulnar nerves in the right hand which may be related to appellant's history of diabetes and represented a mild diabetic neuropathy. Dr. Kelly also advised there may be a component of a mild carpal tunnel syndrome.

On May 27, 2008 an Office hearing representative affirmed the Office's November 14, 2007 decision which found appellant had 12 percent impairment to the right hand.¹

On June 6 and July 21, 2008 appellant requested reconsideration. In an April 6, 2008 report, Dr. Hodge advised he first saw appellant on February 19, 2007 after his crush injury to the right hand. He indicated that appellant recently presented for a second opinion on an impairment rating. Dr. Hodge noted referring appellant to obtain various flexion and grip strength measurements. Based on the A.M.A., *Guides*, he found that appellant had 2 percent impairment of the thumb, 26 percent impairment of the index finger, 51 percent impairment of the middle finger, 56 percent impairment of the ring finger, and 58 percent impairment of the little finger. Dr. Hodge converted those figures to hand and upper extremity impairment. Based on Table 16-1, page 438, he found thumb impairment was 1 percent, index finger impairment was 5 percent, middle finger impairment was 10 percent, ring finger impairment was 6 percent, and little finger impairment was 6 percent, for a total hand impairment of 28 percent. Under Table 16-2, page 439, Dr. Hodge converted 28 percent hand impairment to 25 percent arm impairment. He noted that appellant had lack of grip strength which averaged 61 percent. Based on Table 16-34, page 509, 61 percent strength loss equated to 30 percent impairment of the arm. Dr. Hodge combined the 30 percent strength impairment with 25 percent right arm impairment to find 55 percent total right arm impairment.

In an August 16, 2008 report, an Office medical adviser reviewed Dr. Hodge's April 6, 2008 report. He noted that Dr. Hodge did not make any of the measurements that were recorded. The medical adviser opined that Dr. Hodge's report failed one of the first requisites of an impairment rating report as discussed in section 2.2 of the A.M.A., *Guides* as the impairment evaluation was not performed by a licensed physician. He further advised that appellant's current history was not mentioned in Dr. Hodge's report. Thus, the medical adviser opined that Dr. Hodge's report contained an incomplete data base with respect to evaluation parameters that must be considered in an impairment rating report as set forth on pages 21 and 22 of the A.M.A., *Guides*. As the evidence submitted lacked documentation regarding appellant's current history and failed to contain examination findings made by a physician, he opined it was inappropriate to rate from sections 16.8 on pages 508 and 509. The medical adviser opined that Dr. Hodge's April 6, 2008 report provided no basis to revise appellant's schedule award.

By decision dated August 29, 2008, the Office denied modification of its prior decision.

On October 9 and 17, 2008 appellant requested reconsideration. In an October 8, 2008 report, Dr. Hodge noted that he made a mistake in his previous impairment rating when he included grip strength with appellant's motion deficits. He advised that he examined appellant and recalculated his permanent impairment, which equated to a total hand impairment of 36 percent. Dr. Hodge indicated that the thumb had 56 degrees of flexion at the IP joint and 47 degrees of flexion at the MP joint. The index finger had 50 degrees of flexion at the DIP joint, 75 degrees of flexion at the PIP joint and 52 degrees flexion at the MP joint. The middle finger had 30 degrees flexion at the DIP joint, 60 degrees flexion at the PIP joint, 61 degrees of flexion at the MP joint. The ring had 28 degrees flexion at the DIP joint, 66 degrees of flexion at the PIP

¹ Appellant returned to work as a modified maintenance mechanic effective March 3, 2008. By decision dated June 2, 2008, the Office determined that appellant's employment as a modified maintenance mechanic fairly and reasonably represented his wage-earning capacity.

joint and 36 degrees flexion at the MP joint. Dr. Hodge also found a 28 degree extensor lag at the ring finger PIP joint and 20 degree extensor lag at the MP joint. His small or little finger had 30 degrees flexion at the DIP joint, 56 degrees flexion at the PIP joint, and 22 degrees flexion at the MP joint. Utilizing the charts and tables from the A.M.A., *Guides*, Dr. Hodge advised appellant's thumb had 2.705 percent impairment, the index finger had 31 percent impairment, the middle finger had 73 percent impairment, the ring finger had 84 percent impairment and the little finger had 64 percent impairment. He converted those impairments to hand impairments and found 1 percent thumb impairment, 6 percent index finger impairment, 15 percent middle finger impairment, 8 percent ring finger impairment, and 6 percent little finger impairment for a total 36 percent hand impairment.

In a November 11, 2008 report, the Office medical adviser found Dr. Hodge's report not acceptable for a review of a right hand schedule award determination. He noted that, while Dr. Hodge's October 8, 2008 report contained range of motion measurements for all five digits, the statement of accepted facts and the medical records indicated that the only affected digits due to the work injury were the third and fourth digits of the right hand. The Office medical adviser additionally opined that Dr. Hodge's report was not complete as he did not provide all the necessary factors for an impairment report as outlined on pages 21 and 22 of the A.M.A., *Guides*. He further noted that it was not possible a thumb rating could be 2.705 percent under Figures 16-21 and 23 and that the thumb was not affected by the work injury according to all the medical documentation.

By decision dated November 18, 2008, the Office denied modification of its previous decision.

On February 12, 2009 appellant requested reconsideration. He submitted a copy of the November 17, 2008 order for physical therapy, physical therapy notes from December 9, 2008 through January 14, 2009, a January 19, 2009 discharge report and a copy of Dr. Hodge's October 8, 2008 report along with his letters of November 15 and January 22, 2009.

In a March 20, 2009 report, an Office medical adviser opined that there was no medical basis to accept impairment to digits other than the third and fourth digits as being work related. He reiterated that the medical documentation from Dr. Hodges could not be used to expand the acceptance of injury or increase appellant's impairment due to the accepted conditions as his reports did not contain sufficient documentation as required by the A.M.A., *Guides*, on pages 21 and 22.

By decision dated April 17, 2009, the Office denied modification of its prior decision. On appeal, appellant argued the work injury of January 10, 2007 impacted more than just two fingers. He advised it severely reduced his grip and arm strength and left him with pain and limited ability to do his work as a mechanic.

LEGAL PRECEDENT

The schedule award provision of the Federal Employees' Compensation Act² and its implementing regulations³ set forth the number of weeks of compensation to be paid for permanent loss, or loss of use of the members of the body listed in the schedule. Where the loss of use is less than 100 percent, the amount of compensation is paid in proportion to the percentage of loss of use.⁴ However, neither the Act nor the regulations specify the manner in which the percentage of impairment shall be determined. For consistent results and to ensure equal justice for all claimants, the Office adopted the A.M.A., *Guides* as a standard for determining the percentage of impairment and the Board has concurred in such adoption.⁵ A claimant may seek an increased schedule award if the evidence establishes that he sustained an increased impairment at a later date causally related to his employment injury.⁶

ANALYSIS

The Office accepted appellant's claim for crushing injury of right hand, except fingers, and right hand abrasion or friction burn without infection. On November 14, 2007 appellant received a schedule award for 12 percent impairment of the right hand based on the Office medical adviser's review of Dr. Varghese's second opinion October 24, 2007 report, which found only the third and fourth digits of the right hand were involved. He requested reconsideration and submitted additional evidence but the Office denied any greater award. The Board finds that the case is not in posture for decision as to whether appellant is entitled to an increased schedule award based on his accepted work-related conditions.

In determining whether appellant was entitled to more than 12 percent impairment to the right hand, the Office relied upon its Office medical adviser review of Dr. Hodge's April 6 and October 8, 2008 medical reports. While the Office medical adviser opined that Dr. Hodge's reports were insufficient to base an impairment rating determination, the Board finds further development from the Office is necessary.

The Office medical adviser dismissed Dr. Hodge's April 6, 2008 report on the basis that it lacked documentation regarding appellant's current history and failed to contain examination findings made by a physician. He dismissed Dr. Hodge's October 8, 2008 report for similar reasons. The record reflects, however, that Dr. Hodge had treated appellant since about five weeks post injury. Additionally, while the Office medical adviser discredited Dr. Hodge because he did not perform the impairment evaluation, section 2.2, page 18 of the A.M.A., *Guides* allows Dr. Hodge to incorporate another's examination findings as his own. Furthermore, Dr. Hodge's October 8, 2008 report was based on a new examination and the physician provided new range of motion measurements.

² 5 U.S.C. §§ 8101-8193; *see* 5 U.S.C. § 8107(c).

³ 20 C.F.R. § 10.404.

⁴ 5 U.S.C. § 8107(c)(19).

⁵ 20 C.F.R. § 10.404.

⁶ *Linda T. Brown*, 51 ECAB 115 (1999).

Dr. Hodge stated in his October 8, 2008 report that he had made a mistake in his previous impairment rating when he included grip strength with appellant's motion deficits. He then reexamined appellant and recalculated his permanent impairment of a total hand impairment of 36 percent. The Office medical adviser, however, again discredited Dr. Hodge's report on the basis he did not provide all the necessary factors for an impairment rating. Although the Office medical adviser stated that the statement of accepted facts and the medical record limited the affected digits due to the work injury to the third and fourth fingers of the right hand, the record indicates that the Office accepted a hand injury and there is no finding of record which limits the acceptance of appellant's work-related injury to just two fingers. In any event, the medical adviser did not attempt to use the findings provided by Dr. Hodge to determine if they merited any additional impairment under the A.M.A., *Guides* for any of appellant's fingers.

Office procedures indicate that, when an Office medical adviser, second opinion specialist or referee physician "renders a medical opinion based on a statement of accepted facts which is incomplete or inaccurate or does not use the statement of accepted facts as the framework in forming his or her opinion, the probative value of the opinion is seriously diminished or negated altogether."⁷ The statement of accepted facts in this case indicates that appellant sustained a crushing injury of the right hand and a right hand abrasion. The Office medical adviser provided no explanation as to why the accepted condition was limited to the third and fourth digits of the right hand when Dr. Hodge initially found limited range of motion to the middle, ring and small fingers when he diagnosed a crush injury to appellant's right hand. Additionally, the record reflects appellant may have a preexisting condition, such as a diabetic neuropathy, which affects his arm. It is well established that in determining the amount of a schedule award for a member of the body that sustained an employment-related permanent impairment, preexisting impairments are to be included.⁸ Moreover, on appeal, appellant contends that the work injury affected his arm. When impairment extends into an adjoining area, the schedule award should be made for the larger member.⁹ Thus, the Office medical adviser did not provide sufficient reasoning or base his medical opinion on an accurate medical history when he rendered his opinion on Dr. Hodge's reports. The Board notes that, while Dr. Hodge's October 8, 2008 report did not clearly indicate how the ranges of motion provided correlated to the A.M.A., *Guides* under Figures 16-21, 23, and 25 or other applicable tables or figures, the Office medical adviser did not attempt to rate impairment based on Dr. Hodge's findings other than to note that the 2.705 percent thumb finding was not supportable under the A.M.A., *Guides*. The medical adviser did not indicate whether Dr. Hodge's other specific findings from his October 8, 2008 examination of the hand provided a basis under the A.M.A., *Guides* for more than 12 percent impairment of the hand. Since the Office medical adviser did not render a sufficiently reasoned medical opinion based on a complete medical and factual history, the probative value of his report is limited. Accordingly, the Board finds that the case must be remanded for further medical development.

⁷ Federal (FECA) Procedure Manual, Part 3 -- Medical, *Requirements for Medical Reports*, Chapter 3.600.3 (October 1990).

⁸ *Lela M. Shaw*, 51 ECAB 372 (2000).

⁹ *Janet L. Adamson*, 52 ECAB 431, 434 (2001). The Board also notes that Dr. Varghese converted appellant's impairment rating to a rating for the arm but the medical adviser rejected impairment extending beyond the hand without providing any particular medical reasoning.

Proceedings under the Act are not adversarial in nature nor is the Office a disinterested arbiter. While the claimant has the burden to establish entitlement to compensation, the Office shares responsibility in the development of the evidence. Once it has begun an investigation of a claim, it must pursue the evidence as far as reasonably possible. The Office has an obligation to see that justice is done.¹⁰

The case, therefore, will be remanded for further medical development including a reasoned medical opinion explaining whether appellant has any greater impairment due to his accepted right hand injury than that which the Office has already granted and also whether any such impairment extends from the hand to the arm.

CONCLUSION

The Board finds that this case is not in posture for decision to determine whether appellant has more than 12 percent permanent impairment of his right hand, for which he previously received a schedule award.

ORDER

IT IS HEREBY ORDERED THAT the decision of the Office of Workers' Compensation Programs dated April 17, 2009 is set aside and the case is remanded for further proceedings consistent with this decision.

Issued: April 9, 2010
Washington, DC

David S. Gerson, Judge
Employees' Compensation Appeals Board

Colleen Duffy Kiko, Judge
Employees' Compensation Appeals Board

James A. Haynes, Alternate Judge
Employees' Compensation Appeals Board

¹⁰ A.A., 59 ECAB ____ (Docket No. 08-951, issued September 22, 2008).